Emergency Units in Hospitals

Guidelines

Canada

Report of the Subcommittee
on Institutional Program Guidelines

Guidelines for Establishing
Standards for Special Services
in Hospitals

EMERGENCY UNITS IN HOSPITALS

Health Services Directorate
Health Services and Promotion Branch

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NOTE

The information contained in these guidelines is considered current as of the date of approval; however, since many aspects of health care and health technology are constantly changing, we welcome any suggested amendments. Information on new developments or related issues should be directed to:

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Further copies of these guidelines, in English and in French, can be obtained from the above address.

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PREFACE

Technological advancement and changes in the delivery of health care services have led to the need for guidelines to assist in planning and implementing institutional programs and services. The guidelines that follow represent one of a series of publications produced under the direction of the Subcommittee on Institutional Program Guidelines. They provide a consistent definition of the requirements for a number of special care units, services and programs in health institutions (hereafter in the introduction referred to as services).

In general, guidelines are based on information, knowledge, experience, research and expert opinion from health professionals and organizations throughout Canada. This method allows many Canadians from across the country to contribute to the guidelines, hence a consensus on the suggested approach can be achieved. Additional material is often obtained from national and international health organizations and from other experts knowledgeable in the subject matter.

Background

Under the direction of the Federal/Provincial Advisory Committee on Institutional and Medical Services, the guidelines program has been in operation since 1972. A standing Subcommittee of the Advisory Committee, the Subcommittee on Institutional Program Guidelines, composed of federal and provincial government and professional representatives, coordinates the development of the guidelines commissioned by the Advisory Committee.

The guidelines are produced by the expert working groups of health professionals, some of whom are government representatives. The final draft is reviewed and recommended by the Subcommittee for approval by the Advisory Committee.

Purpose

The purpose of the guidelines is to provide a comprehensive outline of requirements for services in health institutions. While a consensus of expert knowledge and experience is reflected in the guidelines, these should not be regarded as rigid standards. Provincial health authorities may modify the application of the guidelines to meet their needs.

Where development of a service is being contemplated, we believe the guidelines will be of help in determining the need for such a service, either locally, regionally or in some cases provincially or interprovincially.

Established services may take advantage of the guidelines in screening deficiencies and solving problems without having to develop new services. Where a service already exists, the guidelines will help:

- to identify problems related to administration, personnel, equipment and facilities,

- to determine necessary remedial action,

- to set priorities for corrective measures on the basis of clinical need, funding and the degree to which the service is deficient.

Future

The dramatic increase in the number of intensive and special care services in health institutions has given rise to the need for additional facilities, specialized equipment and highly trained personnel. At the same time, new approaches to patient care have evolved. These emphasize the need for a continuum of care in which admission to an institution is only one aspect of total care. Therefore, linkages along the health care continuum, ranging from illness prevention to chronic care, must be identified. As new treatments and procedures are put into practice, there will be a continuing need for guidelines to assist those involved in the planning and operation of institutional services.

Revisions

Due to the rapidly changing nature of health care delivery, guidelines will need updating and revision. The Subcommittee on Institutional Program Guidelines plans and oversees these revisions.

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EMERGENCY UNITS IN HOSPITALS

DEFINITION

An emergency unit is a facility specifically designed, staffed and equipped to triage[1] and which provides the appropriate assessment and management for those patients presenting with illness or injury.

PREAMBLE

It is suggested that provincial and other appropriate authorities assess all hospitals to ensure that an optimum level of care is being provided in the emergency units. The review should include assessment of the capability of each emergency unit and its supporting departments and services.

The two main components to be considered in development of the guidelines for hospital emergency units are the provision of patient care and the effective utilization of resources by and within the community as a whole. For example, in those areas where there is a facility with minimal capability near another facility with more extensive support services, it may be preferable to have emergency care provided by the more capable facility if the travel time is short, and if those accompanying the patient can provide life support for that period.

Each hospital has a different ability to deliver emergency services to the community. The responsibilities of each hospital should be determined taking into consideration its geographical location, and the other medical services available within the community.

Emergency services should be available 24 hours a day. Any hospitals that do not provide 24-hour emergency services should provide public notification and signs indicating where such care may be obtained. Hospital road signs should be designed to indicate where emergency care can be obtained during the 24-hour period.

An emergency unit functions organizationally as an intrinsic part of the hospital and within an emergency health services system. It should have the ability to arrange for continuing acute care following basic

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[1] Triage: the sorting of patients according to the urgency of their presenting problems: emergent or life-threatening-requiring immediate care; urgent-requiring care within hours; non-urgent or deferrable.

emergency treatment. Any hospital that does not fulfill these conditions should not publicly designate itself as providing an emergency unit.

It may be necessary to develop an alternative approach to deal with non-urgent patients who use the emergency unit as a means of entry into the health care system. Such use may interfere with the unit's capability to deal with true emergency patients. Consideration should also be given to a formalized arrangement which will ensure continuing care and adequate follow-up of patients being presented to the emergency unit.

The Pre-hospital Emergency Care System has been addressed in separate guidelines[2]; however, the components of the Pre-hospital Emergency Care System and their interface with the hospitals should be recognized. These components include such things as public awareness and knowledge of first aid and basic life support, organized emergency care and transportation systems, such as ambulance services, advanced life support, communications systems (public and Emergency Medical Service (EMS) systems), as well as disaster planning. Pre-hospital and in-hospital interfaces are presented in Appendix I.

GUIDELINES

1. Patient Distribution

1.1 Categorization of Emergency Units

Emergency units within each province should be categorized by the appropriate health authority following discussion with the provincial ministry of health. All emergency units should be included in this categorization.

Emergency units in Canadian hospitals should be capable of assessing, stabilizing and where necessary facilitating the transfer of patients with acute illness and injury. Based on their capacity to carry out these responsibilities, active emergency units in Canada may be assigned one of four categories:

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[2] Department of National Health and Welfare, "Pre-hospital Emergency Services - Guidelines", Ottawa, Canada, 1985.

comprehensive emergency units

major emergency units

general emergency units

basic emergency units

Those facilities which do not have this capability should not be identified to the public as having an active emergency unit and need not be categorized.

The category designation of a given unit should be based upon: (1) the triage classification of the unit's patients, (2) the volume of patients, (3) the resources (personnel, equipment and physical spaces) available to that unit, as outlined in Table I and Section 6.

Comprehensive emergency units are located in tertiary care university teaching hospitals or health sciences centres in large communities, and have 24-hour in-unit emergency physician coverage and 24-hour in-house availability of critical care specialty services.

Major emergency units are located in an urban or suburban (teaching or non-teaching) hospitals, and have 24-hour in unit emergency physician coverage and prompt[3] but not necessarily in-house availability of other critical care specialty services. The volume of emergency patients is usually greater than 40 000 per year.

General emergency units are located in suburban or rural hospitals, and have 24-hour prompt in-house but not necessarily in-unit emergency physician coverage. Critical care specialty services may not be promptly available. These units have the capacity to resuscitate, stabilize and when necessary facilitate transfer of the critically ill or injured. The volume of emergency patients is usually between 10 000 and 40 000 patients per year.

Basic emergency units include all other active emergency units. They are usually located in smaller, rural hospitals with the emergency physician promptly available but not necessarily in-house. Critical care specialty services are not usually available. These units should have the capacity to resuscitate, stabilize and facilitate transfer of the

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[3] In all cases, the definition of "prompt availability" should be the subject of written hospital board policy.

acutely ill or injured patient. The volume of emergency patients is usually less than 10,000 per year. (For the recommended minimum requirements for basic emergency units, see Appendix III.)

1.2 Transfer Guidelines

Policies and procedures for stabilization and transfer of emergency patients are required for all emergency units (see Appendix IV).

1.3 Patient Triage

A nurse should be immediately available to triage arriving patients by determining the nature and urgency of their problems.

1.4 Non-urgent Patients

Emergency units with large patient volumes (a) should consider establishing a contiguous but separately staffed area for the care of patients presenting with non-urgent problems, and (b) should not have booked procedures or clinics carried out in the emergency unit.

1.5 Patients for Observation

No patient should remain in the emergency unit for longer than 12 hours without a decision having been made as to the patient's disposition.

Beds should be available within the unit for emergency unit patients who require short-term observation. This generally should not include patients recovering from anaesthesia or transfers from other outpatient services. After 12 hours, the patient requiring continuing observation should be admitted as an inpatient or transferred elsewhere.

1.6 Patients for Hospital Admission

Once the patients have been admitted as inpatients, they should not remain in the emergency unit for longer than a further 6 hours. Sufficient in-hospital beds should be available within the community for the admission of acute cases. This will require co-operation amongst the hospitals in the community, and may include the establishment of a central bed registry and appropriate hospital admitting policies, and may require special transportation services.

2. Distribution of Units

Having assessed and categorized the emergency services in all hospitals, the appropriate health authority should organize an emergency medical system which recommends a selection and referral pattern utilizing the available resources in the best interests of the community. Consideration should be given to:

- the availability of resources for the management of patients with serious illness or injury;
- pre-hospital services available and the supportive care that can be provided in transit;
- distances between facilities;
- each hospital's specific resources and support services;
- the availability of health care services other than those being provided for patients with serious illness or injury;
- the existing referral patterns;
- the availability of adequate financial resources.

3. Administrative Policy, Procedures and Control

Written policies and procedures for emergency services should be developed by the medical and nursing staff and other appropriate personnel and be approved by the Board and Administration. These should be readily accessible to all staff as required.

The policies and procedures should be reviewed annually, revised as necessary and dated to indicate the time of the last review or revision.

The hospital should establish appropriate channels for the discussion of policies, procedures, problems, goals and objectives in the emergency unit, with recommendations recorded in writing, and directed to the appropriate hospital committees including the Medical Advisory Committee.

An Emergency Unit Committee representing medical, nursing, related patient services and administration should be formed. This committee should meet regularly to discuss problems, seek solutions,

develop and review policies, review the service provided, undertake quality assurance evaluations and make recommendations for patient care.

3.1 Responsibilities of Staff

Medical Direction

The Governing Board of the Hospital should designate a physician responsible for the medical care of emergency unit patients (hereinafter referred to as "medical director of the emergency unit"). This physician should be granted sufficient scope and authority to oversee the unit in collaboration with the unit supervisor. (In some institutions, this may be combined with other responsibilities). Hospitals may find it necessary to consider compensation commensurate with the administrative duties involved.

The medical director of the emergency unit should act as chairman of the Emergency Unit Committee and should have an independent voting position on the medical advisory committee. Consideration should be given to affording hospital departmental status to emergency units.

Nursing Direction

Nursing administration should designate a unit supervisor who will be responsible for the nursing care of emergency unit patients. This nurse should be granted sufficient scope and authority to oversee the unit in collaboration with the medical director of the emergency unit. The unit supervisor should have a voting position on the Emergency Unit Committee.

Other Staff

The duties and responsibilities of all other staff should be clearly defined in writing.

3.2 Policies and Procedures

Emergency patient care should be guided by written policies and procedures incorporated into readily accessible manuals in the emergency unit. These manuals should be reviewed regularly by the appropriate hospital committees, and should include, as a minimum, policies and procedures regarding patient care and limitations, patient transfers, medical care and responsibilities, nursing care and responsibilities, the organization of the unit, legal issues, patient care records, patient care audits and other quality assurance procedures, and

other subjects. The quality assurance review for the unit should be carried out in an interdisciplinary approach, and should be coordinated with the hospital's quality assurance program and any regional quality assurance programs (e.g. for ambulance services). A more complete description of these appears in Appendix IV.

4. Staff Guidelines

4.1 Medical Staff

4.1.1 Medical Director of the Emergency Unit

All units should be under the direction of a physician with expertise and qualifications in emergency medicine as outlined in Table 1 (Page 9).

The medical director's time commitment should be related to unit categorization (Table 1).

The administrative component of the position should be funded through the hospital operating budget.

4.1.2 Medical Staff

Both full-time and part-time physicians should be considered for active staff appointment in all emergency units. It is expected that in comprehensive units, full-time physicians will represent the majority of the medical staff. In major hospitals, there will be a mix of full-time and part-time staff. In general and basic emergency units, part-time physicians will likely predominate.

All physicians staffing emergency units should have training and experience in emergency medicine as outlined in Table 1.

Appointments to the emergency unit medical staff should be made annually.

Hospitals may have house staff as primary contact physicians only if there is medical staff supervision within the unit.

Consideration should be given to defining an appropriate minimum number of hours on duty annually in the emergency unit for each physician.

4.1.3 Medical Staff Orientation and Continuing Education

All part-time and full-time medical staff should receive a thorough orientation to the emergency unit prior to being assigned responsibility for patient care.

All physicians who staff emergency units should acquire and maintain skills in the initial care of acutely ill or injured adult and pediatric patients.

All hospital emergency units should set up programs in emergency continuing medical education for staff or arrange for training opportunities off-site.

All physicians regularly working in the unit should show evidence of relevant continuing education, including the necessary recertification in emergency medical procedures, for re-appointment on an annual basis.

Arrangements for participation in joint rounds and seminars with other in-hospital services should be established.

4.2 Nursing Staff

4.2.1 Nursing Unit Supervisor

The Unit Supervisor should be a registered nurse with at least two years emergency nursing experience and additional qualifications as outlined in Table 1. These qualifications reflect the changing role of the Unit Supervisor and the need for administrative knowledge to participate as a member of the emergency management team.

4.2.2 Clinical Instructor/Teacher

The Clinical Instructor/Teacher should be a registered nurse with at least two years emergency nursing experience, and should have appropriate instructional skills and additional qualifications (Table 1).

TABLE I

STAFF GUIDELINES AND QUALIFICATIONS

Legend:

Category - C = Comprehensive, M = Major, G = General, B = Basic

Level - E = Essential, R = Recommended, D = Desirable

	Category C	M	G	B
Medical Staff				
1. Medical Director of the Emergency Unit				
- Budget support	E	E	R	D
- In-unit location	E	E	R	D
- Time commitment to Emergency Medicine[7]	100%	75-100%	25-100%	to 25%
- Pre-licensure training in Emergency Medicine	E	E	E	E
- Qualifications in Emergency Medicine:				
FRCPC[4] or	R-E[6]	R	D	-
CCFP(EM)[5]	E	E	R	D
2. Emergency Physicians				
- Time commitment to Emergency Medicine[7]	100%	25-100%	25-100%	to 25%
- Pre-licensure training in Emergency Medicine	E	E	E	E
- Qualifications in Emergency Medicine				
FRCPC[4] or	R-E[6]	D-R[6]	D	-
CCFP(EM)[5]	E	R	D	D

4. Certification in Emergency Medicine by the Royal College of Physicians and Surgeons of Canada.
5. Certification of Special Competence in Emergency Medicine by the College of Family Physicians of Canada.
6. Will depend upon human resource availability.
7. Each hospital will define by policy minimum time required for the emergency physician to retain skills.

TABLE I: STAFF GUIDELINES AND QUALIFICATIONS (cont'd)

Legend:

Category - C = Comprehensive, M = Major, G = General, B = Basic

Level - E = Essential, R = Recommended, D = Desirable

	Category			
	C	M	G	B
Nursing Staff				
1. Unit supervisor				
Post-basic emergency nursing certificate[8]	E	E	R	D
Introduction to Nursing Management Course (CHA-CNA) or equivalent[9]	E	E	R-E[10]	D
1 year of nursing management experience	E	E	R-E[10]	R
Baccalaureate degree in Nursing	D-R[10]	D-R[10]	D	D
Masters degree in Nursing	D	D		
2. Clinical Instructor/Teacher				
Post-basic emergency nursing certificate[8]	E	E	R	D
Baccalaureate degree in Nursing	D-R	D	D	D
3. Unit Nursing Staff/Triage Nurses				
Post-basic emergency nursing certificate[8]	R	R	R	D

8. Where post-basic emergency nursing courses are not available, critical care certificate courses are recommended.
9. Components of the Introduction to Nursing Management course may be included in the baccalaureate degree in nursing.
10. Will depend on human resource availability.

4.2.3 Nursing Unit Staff

The emergency unit registered nurse should have at least two years recent experience in acute medical and surgical nursing, should have completed a post-R.N. emergency nursing course, and may have additional qualifications (Table 1).

The triage nurse should be a registered nurse with at least two years emergency nursing training and experience, and may have additional qualifications (Table 1).

All nurses who staff emergency units should maintain skills in the initial care of acutely ill or injured adult and pediatric patients.

Consideration should be given to designating an appropriate minimum number of hours on duty in the emergency unit for registered nurses who are not working full time in the Emergency Unit.

4.2.4 Other Support Staff

Requirements for nursing auxiliary personnel, such as nursing attendants, receptionists/clerks, porters and aides, will vary with the size and categorization of the unit and the type of patients treated. The duties and responsibilities should be delineated in writing.

These staff members should maintain skills in basic life support procedures.

4.2.5 Factors Affecting Staffing

The number of nursing and support personnel required to staff a given unit will depend upon various factors, including:

- the number of patients and their triage classifications
- periods of peak workload
- the physical layout of the emergency unit
- the number of emergency admissions to the operating room and hospital
- the length of patient stay in the emergency unit after admission to the operating room or hospital
- the number and types of nursing interventions provided

- the amount of patient-care and non-patient-care activities
- the staff time involved in patient transfers to other facilities
- the scope of services provided in the emergency unit
- medical staff coverage

Scheduling patterns should provide for the continuous presence of a registered nurse with the seriously ill or injured patient from arrival until admission, transfer or discharge.

Observation areas should be separately staffed by sufficient numbers of registered nurses.

An emergency unit workload measurement system should be used to calculate the number of staff hours required. One such system is the Canadian Emergency Workload Measurement System developed by the National Hospital Productivity Improvement Program.[11]

4.2.6 Nursing Orientation and Continuing Education

All full-time and part-time registered nursing staff should receive a thorough orientation to the emergency unit before being assigned independent responsibility for patient assessment and care. The orientation program should include classroom instruction and supervised clinical practice, and should consider the previous training and experience of the individual nurse. For a nurse with little or no prior emergency experience, this may require up to 225 hours.

Continuing education in emergency/critical care should be available on an in-service or regional basis. Major and comprehensive emergency units should consider providing regional continuing education programs to promote an effective interface with other emergency units.

Registered nurses should attend at least one emergency care course per year, in addition to training in basic and advanced life support programs.

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11 Department of National Health and Welfare "Emergency Department Workload Measurement System", National Hospital Productivity Improvement Program, Ottawa, Canada, 1986.

4.3 In-unit Support Services

4.3.1 Social Services

Appropriate social services including crisis intervention should be provided for emergency units. Where not available, emergency unit staff should access community resources. Updated listings should be kept in the unit.

4.3.2 Pastoral Care

Religious advisers play an important role in patient care and in the care of patients' friends and relatives. Ideally, they should be available on a 24-hour basis; otherwise, a list of ministers available on call should be kept in the emergency unit.

4.3.3 Interpreter Services

A list of the names of staff and citizen volunteers willing to act as interpreters on short notice should be maintained in the emergency unit. An orientation program for these volunteers is desirable.

4.3.4 Public Relations

A staff member with responsibilities for public relations and skilled in interacting with the public and the media is an important aid to the professionals who deliver care in the emergency unit.

4.3.5 Volunteer Services

Volunteers provide a valuable service to the emergency unit staff by carrying out duties of a non-medical nature. They should receive an orientation, have a job description and work according to hospital policies.

4.3.6 Security

Security personnel should be readily available to the emergency unit. If not stationed in the emergency unit, a protocol for prompt response should be established. In high-risk areas, a rapid communication system to the local police station should be considered.

5. Hospital Support Services

Hospitals should ensure that the quality of support services available to emergency unit patients is equal to those available to inpatients and other outpatients. Quality assurance mechanisms for inpatient support services, particularly laboratory and imaging services, should be extended to include those services provided to emergency unit patients. Appropriate staff coverage of support services for emergency unit patients should be arranged.

The availability of in-hospital services in a large part determines the categorization of a hospital's emergency unit.

5.1 Consultant Services

The following critical care consultant services should be available 24 hours a day for all emergency units:

Anesthesia
General Surgery
Internal Medicine
Neurosurgery[12]
Obstetrics and Gynecology[12]
Pediatrics

The availability of consultant services should be as follows:

Comprehensive Units - In-house
Major Units - Promptly available but not necessarily in-house
General Units - On call
Basic Units - As available or as can be arranged with referral facilities

Other consultant services not listed above should be promptly available according to needs defined by each hospital.

5.2 Special Services

For all units, appropriate personnel should be available in-house 24 hours a day to respond to cardiac arrests.

Personnel required for response to major trauma patients should be available according to the needs of each hospital (see Appendix V C).

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12 Where appropriate.

The following special services should be available 24 hours a day for each emergency unit:

- Intensive/Coronary Care
- Operating/Post-Anesthetic Recovery Rooms
- Respiratory Therapy Service
- Imaging Subspecialties[13]
- Clinical Laboratory Services

The availability of these special services should be as follows;

Comprehensive and Major Units - In-house
General Units - On call
Basic Units - As available or as can be arranged with referral facilities

Other special services not listed above should be available according to the needs defined by each hospital.

6. Regional Services

Regionalization of services in some parts of the country has resulted in certain types of specialized care being available only in specifically identified hospitals, e.g. trauma units, burn units, sexual assault units, perinatal units, spinal cord injury units.

Policies and procedures should be in place with respect to referral or transfer of patients to these units.

7. Space Requirements and Special Design Features

7.1 General Features

The entrance to the emergency unit should be clearly indicated and sufficiently distant from the main hospital entrance and parking area to expedite traffic flow.

Consideration should be given to ease of access and travel time between the emergency unit and its supporting departments and services, such as hospital admitting department, diagnostic imaging, operating rooms, labour and delivery, laboratory, cardiac care unit and intensive care unit.

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13 May include angiography, sonography, nuclear scanning, computed tomography, etc. as appropriate.

To minimize transfer time for patients, particular attention should be paid to planning and use of elevators. Sufficient elevators should be provided and there should be "homing" controls which return at least one elevator to the emergency unit level (with key controls for emergency unit and security personnel).

Readily understood directional sign systems should be available within hospitals[14].

7.2 Space Requirements

Space within the emergency unit can be divided into:

- primary activity space: those areas where patient care is provided
- support space
- administrative space

The major determinants of the amount of space required are:

- number of patients
- number of patients in each triage classification (see footnote 1)
- service times
- length of stay
- unit categorization
- personnel and equipment resources
- periods of peak workload

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14 Department of National Health and Welfare, "Guidelines for a Signage System in Health Facilities," Ottawa, Canada, 1988.

Various guidelines have been developed to project workloads for peak periods on peak days. Suggested guidelines for space requirements for emergency units can be found in the "Space Programming Manual" of Health and Welfare Canada.[15]

7.3 Special Design Features

The following design features are recommended for comprehensive and major units, but should be considered desirable for general and basic units:

General

a. The emergency unit should be located on a level accessible to vehicular traffic. There should be separate but adjacent stretcher and walk-in entrances, each with sliding doors. Wheelchair ramps are necessary for all entrances and exits.

   The ambulance entrance should have an enclosed, heated and ventilated receiving port, capable of accommodating two or more simultaneously unloading vehicles. Ambulance or stretcher patients and walk-in patients should not cross paths.

b. Wide doors and corridors should allow unimpeded passage of stretchers or beds, staff and equipment, and should lead to the triage, resuscitation and treatment areas.

c. Patient care areas should be equipped with patient call systems, intercoms and telephone access.

Primary Activity Areas

a. A reception/triage area should be provided for initial contact between the patient and a nurse. The registration area should be physically separate from the reception/triage area.

   These areas should be subject to direct visual supervision by appropriate emergency unit staff.

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15 Department of National Health and Welfare "Evaluation and Space Programming Methodology," Ottawa, Canada, 1985.

b. Waiting areas should be spacious and provide for smaller groupings of patients and relatives. If possible, separate waiting areas should be provided for adult and pediatric patients and their friends and relatives. Provision should be made for visual monitoring by appropriate emergency unit staff.

c. Resuscitation/major trauma areas are used for patients with immediate life-threatening conditions. They should be as close to the ambulance entrance and triage area as possible.

The design of the emergency unit should incorporate the capability and flexibility to handle the patient load from a multi-casualty incident.

d. Major treatment/acute care areas are used for treating patients with urgent conditions requiring continuing treatment and observation. They preferably should be within one large area with curtain partitions for privacy. This latter arrangement will allow for more efficient observation and care by nursing and physician staff.

e. Minor treatment/minor trauma areas are used for patients with non-urgent conditions. One or more of these areas may be designated for minor operative procedures, e.g. suturing.

f. A gynecological examination room with adjacent two-piece bathroom should be located to ensure privacy.

g. The Eye, Ear, Nose and Throat (EENT) area should be capable of accommodating a stretcher patient and appropriate specialized equipment (see Section 7).

h. The fracture and orthopedic room needs to be sufficiently large to accommodate the management of emergency unit patients with orthopedic problems not requiring operative intervention, e.g. the application of splints and casts. Sufficient storage space for the related equipment is required in or adjacent to the unit.

i. Interview room(s) can be used for such diverse functions as a quiet room, a family room, or for interviews by psychiatrists, social workers, religious advisers, etc.

j. An appropriate room with attached two-piece bathroom for the isolation of infectious patients and the protection of immunocompromised patients is essential.

k. An emergency observation area should be provided for the short-term observation and management of:

i. Emergency unit patients undergoing active emergency treatment. These patients should not remain in this area beyond 12 hours.

ii. Admitted emergency unit patients awaiting in-hospital beds. These patients should not remain in the emergency observation area beyond 6 hours from time of admission.

Patients requiring observation beyond the time limits indicated should be moved to an area separately staffed and physically distinct from the emergency unit.

The size of the emergency observation area should be determined by the volume of emergency unit patients and the number of patients admitted from the emergency unit to in-hospital units.

l. A separate pediatric treatment area should be provided.

m. Consideration should be given to the provision of appropriate areas for the management of patients potentially contaminated with chemicals, radiation, or other hazardous agents.

n. Consideration should be given to the provision of appropriate areas for the secure, safe observation of disturbed, noisy or dangerous patients.

Support Areas

Support areas should include:

- waiting room(s)
- registration area
- nursing station:
  - clerical
  - charting
  - communications
  - monitoring
  - medical charting/dictation
  - central X-ray viewing facility
  - medication room
- soiled utility
- clean utility
- quiet room

- patient toilets
- housekeeping closet(s)
- patient shower
- wheelchair and stretcher storage
- reference resource area
    - texts and manuals
    - poison information
- equipment and supplies storage
- ambulance/police work areas (optional)

Administrative Areas

Administrative areas should include:

- medical director's office
- emergency physicians' office(s)
- nursing unit supervisor's office
- clinical instructor office
- male and female staff facilities
    - toilets
    - lockers
- emergency physicians on-call room (with three piece bathroom)
- conference room
- staff lounge
- nourishment centre/pantry

8. Equipment

The following equipment which is common to all of the rooms is listed below:

- wall-mounted oxygen and suction
- sphygmomanometer
- ophthalmoscope, otoscope
- ceiling mounted IV tracks
- hand-washing facilities

In addition to the above, the following are recommended for comprehensive and major units, and are desirable for general and basic units:

a. Resuscitation room/major trauma room:

Each stretcher space should be equipped with:

- an adjustable, radiolucent tilting trauma stretcher
- cardiac monitor

- airway management equipment - infant to adult
- a high-intensity operating light

The room or area should contain, in addition to the above:

- a resuscitation cart including medications and defibrillator
- cardiac pacing equipment
- X-ray viewing box
- special trays and supplies specific to resuscitation and major trauma
- pneumatic anti-shock garment
- a blood infusion pump
- pediatric drug dosage chart

The following should be promptly available:

- portable X-ray equipment
- blood and blood products
- a blood warmer
- ventilator
- portable oxygen
- volumetric intravenous pumps
- thermal control equipment

b. Major treatment/acute care area:

- adjustable tilting stretcher
- cardiac monitoring capability for each stretcher
- resuscitation cart including airway management equipment, defibrillator and medications

c. Minor treatment/minor trauma area:

- adjustable tilting stretchers
- overhead, high-intensity operating light(s)

d. EENT room:

- EENT examination chair
- ENT examination light
- slit lamp
- visual acuity chart(s)

e. Gynecological examination room:

- examination table with stirrups (or stretcher with these capabilities)
- portable doppler ultrasound
- sexual assault kit
- examination light
- emergency obstetrical delivery tray

f. Isolation room:

- supplies pertinent to handling potentially infectious cases

g. Fracture and orthopedic room:

- automatic tourniquet
- sink with plaster trap
- nitrous oxide - oxygen inhalation analgesia
- adjustable tilting stretcher
- X-ray viewing box
- splinting and casting supplies and equipment

h. Observation area:

- adjustable, tilting stretcher beds

i. Pediatric treatment area(s):

- crib, croupette
- weigh scale
- pediatric airway equipment
- pediatric examination equipment

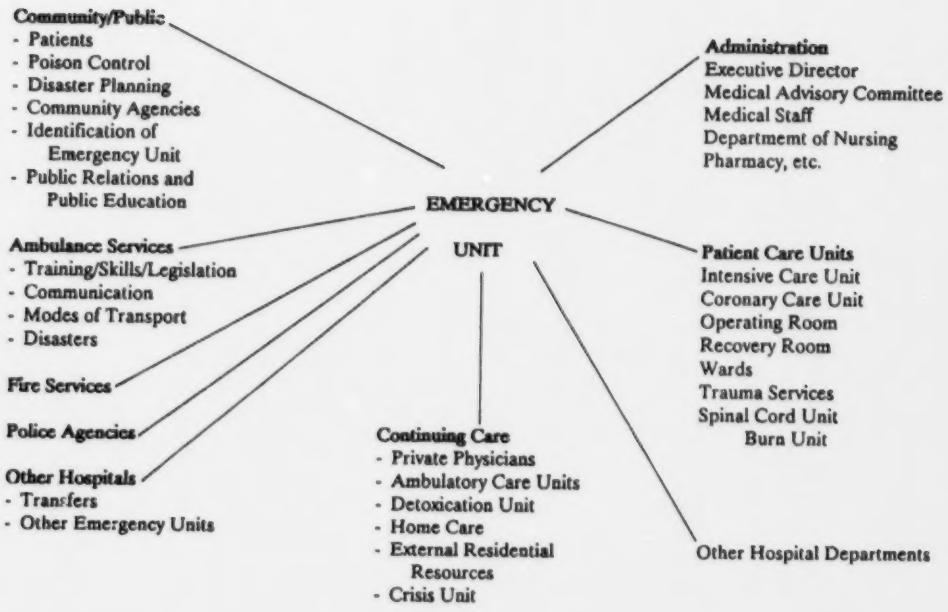
j. Miscellaneous equipment:

- resuscitation and transfer kits for neonates to adults
- portable monitor/defibrillator
- portable oxygen
- portable suction
- portable IV stands
- ECG machine
- disaster supplies
- extra stretchers, wheelchairs

APPENDIX I

EMERGENCY MEDICAL SYSTEM

RELATIONSHIP OF THE EMERGENCY UNIT TO EXTERNAL AGENCIES AND HOSPITAL RESOURCES



ADMINISTRATIVE ORGANIZATION, POLICIES AND PROCEDURES

Guidelines for administrative organization, policies and procedures for institutional programs were formulated after a review of provincial, national and international information.

It is hoped that the following outline will serve as a guide for the development of more comprehensive and specific policies in order to ensure the most effective and efficient delivery of patient care in these units.

I. PHILOSOPHY, ROLES AND OBJECTIVES

- Philosophy, roles and objectives of the program.
- Type of patients served.
  - By diagnosis and/or severity of illness.
  - Restriction of service, if any.
- Services provided.

II. ORGANIZATION OF PROGRAM

- Governing board responsibility.
- Relationship with administrator and medical staff.
- Program management

  (i) Specific responsibilities of staff

  - Medical director
  - Other medical staff
  - Nursing staff
  - Other staff.

  (ii) Committees

  - Membership to be defined by discipline and number
  - Terms of reference to be defined

- Provision for consultation with appropriate hospital and medical staff
- Schedules for formal and ad hoc meetings.

III. POLICIES FOR OPERATION OF PROGRAM

1. General

- Admission authority (Identification of individual(s) who have authority to admit)
- Admission priorities by:
  - Diagnostic category
  - Clinical condition.
- Admission orders.
- Medical orders.
- Emergency admission standing orders.
- Discharge policies and planning.
- Length of stay by diagnosis.
- Infection control and isolation.
- Patient records, reports and charting.
- Handling of emergency situations including C.P.R.
- Emergency delegation of responsibility to medical, nursing and/or other staff.
- Research/clinical investigation.
- Palliative care, determination of death, authorization for autopsies, handling of bodies.
- Referral, consultation (mandatory and other transfer, follow-up).

2 Staff

- Selection criteria: education, experience, interests.
- Criteria for granting medical/clinical privileges.
- Medical coverage/Staff coverage of service.
- Delineation of student and supervisor roles including responsibility, authority and accountability.
- Position descriptions.
- Orientation and continuing education.
- Performance evaluation.
- Volunteers.

3 Patient

- Patients' rights.
- Patient identification.
- Family participation.
- Confidentiality.
- Patient/family education.
- Patient valuables, assets and belongings.
- Consent for treatment.
- Visiting privileges.

4 Safety

- Safety and accident prevention.
- Reporting of accidents and incidents.
- Equipment maintenance and safety.

- Fire and disaster plan.
- Use of restraints.

5 **Quality Assurance**

- Practice standards.
- Continuing evaluation of effectiveness of service.
- Patient status assessment on admission and discharge.
- Incident reports.
- Patient care review.
- Infection control.
- Audits: medical and nursing care, concurrent and retrospective.
- Peer review.
- Morbidity/mortality review.
- Employee performance appraisal.
- Product and equipment use and evaluation.

IV. PROCEDURES

- Elective procedures.
- Emergency alert system procedures.
- Medical record and statistical procedures.
- Policy and procedure manuals.

RECOMMENDED MINIMUM REQUIREMENTS FOR BASIC EMERGENCY UNITS

Emergency unit services should be available 24 hours a day. Those facilities which do not meet the following criteria should not be identified to the public as having an emergency unit.

1. Space Design and Equipment

There should be a specifically designated space for the management of emergency patients. This area should contain the following equipment needed to resuscitate, stabilize and facilitate the transfer of the acutely ill or injured:

1) oxygen and suction
2) sphygomanometer
3) ophthalmoscope, otoscope
4) IV stand(s)
5) adjustable tilting stretcher(s)
6) hand washing facilities
7) a high-intensity operating light
8) resuscitation cart including
   - airway management equipment - infant to adult
   - cardiac monitor - defibrillator
   - medications
9) pneumatic anti-shock garment
10) drug dosage charts - infant to adult
11) croupette
12) visual acuity chart
13) 12 lead ECG machine (readily available)
14) sexual assault kit
15) special trays and supplies for resuscitation and major trauma
16) transfer kit(s) - resuscitation and medications for neonates to adults.

Other equipment may be added at the hospital's discretion.

2. Staffing

2.1 Medical

There should be a physician responsible for the administration of the emergency unit. This physician should have a voting position on the medical advisory committee.

There must be a physician on call 24 hours a day with a written policy outlining the required response time to the emergency unit.

2.2 Nursing

There should be a registered nurse responsible for the administration of the emergency unit.

A registered nurse must be on duty in-house 24 hours a day and promptly available to the emergency unit. The nurse must have the expertise, skills and authority to initiate life-saving techniques.

3. Policies and Procedures

Written policies and procedures should be established including:

- nursing and medical responsibilities
- delegation of medical acts
- procedure for obtaining extra staff
- procedures for dealing with medical/nursing problems
- pre-established transfer agreements
- transfer protocols.

Other criteria for basic emergency units which go beyond these minimum requirements can be found in the body of these Guidelines.

SUBJECTS FOR WHICH POLICIES AND/OR PROCEDURES SHOULD BE ESTABLISHED IN WRITING FOR HOSPITAL EMERGENCY UNITS

1. Patient Care and Limitations

- Communication with pre-hospital care agencies (ambulance, fire, police).
- Triage of patients presenting to the emergency unit.
- Location of and referral procedures for patient services not available in the hospital.
- Processing of patients through the emergency unit.
- Admission criteria and permissible length of stay in the emergency department including any observation area.
- Admission of patients from the emergency unit to inpatient units.
- Procedures NOT to be performed in the emergency unit.
- Cardiopulmonary resuscitation and life support.
- Management of psychiatric patients, including safety precautions for staff and patients, and the use of physical restraints.
- Management of the poisoned patient, including a protocol for telephone enquiries.
- Management of major trauma patients.
- Isolation and management of infectious and/or immunocompromised patients.
- Management of the deceased patient, including notification of the medical examiner/coroner.
- Notification of patient's next of kin.
- Response to a multicasualty incident.

- Management of patients exposed to hazardous materials including radioactive materials, chemicals and biologicals.

- Management of difficult patients.

- Tissue and organ donation.

- Criteria for discharge of patients at risk (e.g. head injury).

- Appropriate follow-up arrangements for patients discharged/released from the emergency unit.

- Redirection of incoming patients in extraordinary circumstances.

2. **Patient Transfers**

- Protocol for the receiving of patient transfers from other facilities or health care workers.

- Determining the need for patient transfer.

- Patient information.

- Consent from patient for transfer.

- Stabilization of patients prior to transfer.

- Contacting receiving physician and hospital prior to transfer.

- Information to receiving hospital and ambulance operator concerning patient (information that could affect preparation for the transfer e.g. suspect communicable diseases).

- Responsibilities of referring and receiving physicians.

- Responsibilities of the transferring nurse and the charge nurses.

- Transfer protocols including selection of the mode of transportation, choice of vehicle, accompanying staff and equipment and supplies (transfer kits).

- Responsibility for patient management during transfer.

- Information to the transferring personnel.

- Information to accompany the patient (records, reports, X-rays; standardized transfer record).

- Transfer arrangements between hospitals where patients are regularly transferred.

- Transfer at the patient's request, against medical advice.

- Transfers in adverse weather conditions.

3. Medical Care and Responsibilities

- Responsibilities, function and authority of the medical director of the emergency unit.

- Appointment of physicians to the emergency unit roster, and assignment of shifts including back-up responsibilities.

- Orientation and monitoring of new emergency physicians.

- Delineation of responsibilities and privileges of physicians attending patients in the emergency unit, including physicians attending their private patients.

- Notification of the patient's private physician.

- Availability and obtaining of specialized laboratory and imaging investigations.

- Time guidelines for patients' physicians to attend to patients in the emergency unit prior to another physician attending the patient, particularly in urgent cases.

- Consultant coverage for the emergency unit, including the maintenance and utilization of on-call rosters.

4. Nursing Care and Responsibilities

- Responsibilities, function and authority of the unit supervisor, including committee memberships.

- Responsibilities and function of the unit nursing staff, including charting responsibilities.

- Delineation of special procedures to be performed by the unit staff, such as defibrillation or venipuncture including the education and validation required.

- Verbal orders from physicians to nurses.

- Minimum staffing levels.

- Obtaining extra staff to accommodate unexpected workloads.

5. **Organization of the Emergency Unit**

- The unit organizational structure, including the lines of authority and the lines of communication between the emergency unit staff and hospital, medical and nursing administration.

- Procedures for dealing with medical/nursing problems

- Job descriptions of the emergency unit staff.

- The disaster plan for the emergency unit.

6. **Legal Issues**

- Management of the abused or neglected child.

- Management of the abused or neglected adult.

- Management of the victim of sexual assault.

- Management of the victim of other crimes.

- Obtaining specimens for blood alcohol determination.

- Consent for treatment, including the provision of care to an unemancipated minor not accompanied by a parent or guardian, and telephone consent.

- Patient refusal of treatment including self-discharge.

- Management of reportable diseases.

- Management of police cases.

- Management of coroner's cases.

7. **Records and Reports**

- Patient confidentiality issues.
- Minimum criteria for emergency unit patient care records.
- Methods of obtaining old charts.
- Patient discharge instructions, including the use of preprinted instructions where appropriate.

8. **Patient Care Audit/Quality Assurance**

- An established mechanism to regularly evaluate and monitor the quality of emergency unit care and performance of the personnel. (To include outcome review, drug utilization review, patient surveys.)
- Automatic audit of all cases of death within 24 hours of arrival to the emergency unit, and reviews of specific morbidities.
- Recall of patients requiring additional studies or treatment.
- Mechanism for the correction of identified deficiencies.
- Scanning for abnormal diagnostic test results prior to filing reports.

9. **Other**

- Public relations and public education.
- Press relations and press releases.
- Social service or community agency referrals.
- Equipment maintenance, power failure contingencies.
- Location, storage and procurement of medications, blood, supplies and equipment 24 hours a day, 7 days a week.
- Accessing required information: reference material, telephone advice, etc.
- Enforcement of hospital policies.

- Safekeeping of patients' belongings.
- Booking elective visits/procedures in other departments.
- Emergency alerts for security problems.
- Visiting regulations for department and hospital.
- Management of persons refusing to leave and patients no longer requiring hospital care.

A. THE TREATMENT OF PEDIATRIC PATIENTS

a) Emergency Units in Children's Hospitals

A number of hospitals across Canada are specifically dedicated to pediatric care. Emergency units in these hospitals should be categorized in the same manner as guidelines. Most will be categorized as comprehensive or major emergency units. Guidelines for medical and nursing direction, as well as for medical, nursing and other staff, should incorporate the spirit of the recommendations outlined for personnel in all other Emergency Units. Required credentials and continuing education programs should emphasize the skills and knowledge related to the management of patients in the pediatric age group. Emergency Unit space and design should be appropriate to the needs of each pediatric centre, as should the equipment, supplies and other resources provided. Written policies and procedures should be readily available within the Emergency Unit.

Just as emergency units in children's hospitals serve as referral centres, their medical and nursing staff should act as resources for the pediatric continuing medical education for other area emergency units.

b) Emergency Units in All Other Hospitals

All emergency units must be prepared to manage patients in the pediatric age group. Written policies and procedures related to pediatric emergency care should be readily available within the emergency unit. Their physicians, nurses and other staff should be skilled in the initial management of urgent and life-threatening pediatric conditions. Continuing education programs should include reviews of pediatric emergencies.

Supplies, equipment and medications for the management of neonates to adolescents should be immediately accessible in all emergency units (e.g. endotracheal tubes and laryngoscopes, ventilation equipment, blood pressure cuffs, cribs and croupettes). Each hospital emergency unit should attempt to provide separate waiting and treatment areas specifically designed for pediatric patients.

Emergency Units without access to in-hospital pediatric resources and expertise should be prepared to stabilize and transfer these patients to centres where these resources are available. Written transfer protocols should be established outlining lines of communication and procedures to be followed in the transfer of these patients.

B. THE TREATMENT OF FAMILY VIOLENCE VICTIMS IN EMERGENCY UNITS

Family violence is a societal problem of increasing concern and refers to the chronic and intermittent abuse of one family member by another.

Generally, family violence is considered to include spouse abuse, child abuse or neglect, and abuse of the elderly.

Victims of family violence frequently seek care in the emergency unit. The challenge to emergency unit staff therefore is to recognize these victims, meet their immediate medical and psychological needs, and refer them appropriately to available community or hospital resources, i.e. identification, evaluation and management, documentation, referral and reporting. To meet this responsibility, hospitals should ensure that:

- Medical and nursing staff in the emergency unit are sensitized to this problem and characteristic symptoms and patterns of injury.

- Medical and nursing staff are familiar with the special principles and techniques for assessment and care of such victims.

- Medical and nursing staff are aware of the legal requirements related to the reporting of suspected cases of child abuse.

- Written policies and procedures are in place to guide the management, documentation and referral of such cases.

- A list of referral services and their respective telephone numbers is readily available in the emergency unit.

Consideration should be given to the development of an interdisciplinary team on call 24 hours a day to assist in the management of these patients.

C. THE TREATMENT OF TRAUMA PATIENTS IN EMERGENCY UNITS

All emergency units must have the capability of dealing with patients presenting with major traumatic injuries. This may involve multiple system injuries in single or multiple casualty incidents.

The ability to manage such patients will depend upon the categorization of the emergency unit but should, as a minimum, include the following:

- initial resuscitation including airway management, fluid resuscitation and spinal immobilization

- stabilization of the patient prior to transfer as per protocols established with other hospitals capable of definitive trauma management.

Emergency units may decide to involve a multidisciplinary team to attend to multiple trauma victims. This may include emergency physicians, anesthetists, general surgeons, and surgeons from other disciplines. The coordination of such a team approach requires guidelines including policies and procedures, both within a given hospital and between hospitals when patient transfer is involved.

LIST OF GUIDELINES FOR INSTITUTIONAL PROGRAMS

The following guidelines have been prepared by the federal-provincial Subcommittee on Institutional Programs Guidelines. These guidelines were requested by the Federal-Provincial Advisory Committee on Institutional and Medical Care Serv ces. Some of the guidelines are updated versions of guidelines previously published by the Subcommittee.

Addiction Services in Hospitals (1984)
Adult Long Term Institutional Care (1984)
Adult Psychiatric Services Provided by General Hospitals (1988)
Assessment and Placement for Adult Long-Term Care: A Single Entry Model (1988)
Breast Imaging Services: Mammography (1986)
Burn Unit (1985)
Cardiovascular Services in Hospitals (1986)
Child and Adolescent Psychiatric Services Provided by General Hospitals (1980)
Child and Adolescent Services in General Hospitals (1982)
Child and Youth Long Term Services (1985)
Computed Tomography (1986)
Day Surgery Unit (1982)
Dental Care Units in Hospitals (1979 under revision)
Diabetic Day Care Unit (1978 under revision)
Diagnostic Imaging Services and Systems: An Overview (1986)
Diagnostic Ultrasound Facilities in Hospitals (1985)
Emergency Services in Hospitals (1988)
End-Stage Renal Disease Program (1986)
Geriatric Day Hospitals - Geriatric Unit in a Hospital (1979 under revision)
Hospital Day Medicine (1984)
Intensive Care Unit (1986)
Magnetic Resonance Imaging (1986)
Nuclear Medicine in Hospitals (1985)
Organ and Tissue Donation Services in Hospitals (1986)
Palliative Care Services in Hospitals (1981 under revision)
Patient Hostel Unit (1978)
Perinatal Intensive Care Units in a Perinatal Care Network (1986)
Pre-Hospital Emergency Services (1985)
Pulmonary Function Laboratories (1982)
Rehabilitation Medicine Program (1986)

Respiratory Therapy Service (1987)
Reuse of Disposables: An Information Report (1985)
Spinal Cord Injury Program (1986)
Stroke Program (1986)
Vital Organ Transplant Centres (1987)